



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSS BARRON – Director

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3232 Elder Street
P.O. Box 83720
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August 18, 2017

Steve Lish, Administrator
Discovery Care Center
600 Shanafelt Street
Salmon, ID 83467-4261

Provider #: 135129

Dear Mr. Lish:

On **August 11, 2017**, a survey was conducted at Discovery Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 28, 2017**. Failure to submit an acceptable PoC by **August 28, 2017**, may result in the imposition of penalties by **September 22, 2017**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 15, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 9, 2017**. A change in the seriousness of the deficiencies on **September 25, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 9, 2017** includes the following:

Denial of payment for new admissions effective **November 9, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 7, 2018**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 9, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 28, 2017**. If your request for informal dispute resolution is received after **August 28, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive style with a large initial "D".

David Scott, R.N., Supervisor
Long Term Care

DS/lj

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2017
NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from August 7, 2017 through August 11, 2017.</p> <p>The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Ina Tso RN</p> <p>Survey Abbreviations:</p> <p>ADL = Activities of daily living AMD = Area Manager for Dietary AMDS = Account Manager Dietary Services B&B = Bowel and Bladder BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CVA = Cerebrovascular accident/stroke DON = Director of Nursing d/t = due to F = Fahrenheit HACCP = hazard analysis critical control point HS = bedtime LOC = level of consciousness LSW = Licensed Social Worker MD = Physician MDS = Minimum Data Set NPO = nothing by mouth NA = Nurse Assistant Oz. = ounce(s) PRN = as needed RD Registered Dietician RN = Registered Nurse r/t = related to Tbsp. = Tablespoon w/c =wheelchair</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/02/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250 SS=D	<p>483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, it was determined the facility failed to ensure social service resources and/or referrals were provided to assist 1 of 10 (#8) residents reviewed for social services and created the potential for harm for residents requiring assessment and/or assistive devices from outside providers. Findings include:</p> <p>Resident #8 was admitted to the facility on 8/17/12, and readmitted on 1/14/17, with diagnoses that included glaucoma, chronic kidney disease, and major depressive disorder.</p> <p>A Social Services Quarterly Evaluation, dated 11/28/12, documented Resident #8 wore hearing aids, but did not experience any communication difficulties.</p> <p>A Social Services Quarterly Evaluation, dated 11/21/15, documented Resident #8's family member would make an audiology appointment as the resident did not wear her current hearing aid.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 11/27/15, documented Resident #8 had difficulty hearing in some environments, including noisy rooms or when others spoke in a quiet voice, and did not have a</p>	F 250	<p>F250 Corrective Actions: Corrective actions for resident #8, was to make a referral to Miracle Ear for an audiology evaluation, which the resident is in agreement with. Appointment was scheduled for 09-08-17. Identification of others affected and corrective actions: Any resident, with hearing variances, could have been affected. These residents will be assessed for a potential change, which may affect the residents hearing. A referral will be made to an audiologist, if applicable, and the resident/family is agreeable. Measures to ensure that the deficient practice does not happen again: The Licensed Social Worker, MDS Nurse and DON will be educated, on the assessment and care planning process, as it relates to hearing. An additional in-service, will be conducted to ensure that referrals are made, if assessed to be appropriate, and desired by the resident. Monitor corrective actions: The administrator or designee will audit for changes that have occurred for 6 weeks for compliance of assessment of hearing, and the possibility of an</p>	9/15/17	

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F 250	<p>Continued From page 2 hearing aid device.</p> <p>A Social Services Quarterly Evaluation, dated 11/15/16, documented Resident #8 experienced "problems hearing conversations and the family has provided an inexpensive hearing device." The evaluation documented an audiology consultation was not needed at that time.</p> <p>On 12/20/16, the quarterly MDS assessment documented Resident #8 experienced difficulty hearing in some environments, such as when someone spoke softly or the room was noisy. The MDS assessment also noted Resident #8 did not have a hearing aid device.</p> <p>On 5/31/17, the annual MDS assessment documented Resident #8 experienced moderate difficulty hearing, and required the speaker to increase volume and speak distinctly. The MDS assessment also noted Resident #8 did not have a hearing aid device.</p> <p>Resident #8's Care Plan, dated 9/1/15 and revised on 8/22/16, documented Resident #8 was at risk for a communication problem related to minimal hearing deficit. Interventions directed staff to increase phone volume when Resident #8 conversed on the phone, consider Resident #8's position when in groups, activities, and the dining room to promote effective communication with others, and advised that Resident #8 wore one hearing aid in the left ear.</p> <p>On 8/8/17 at 10:00 am, Resident #8 was observed attending a group activity where she did not have a hearing aid in either ear. Resident #8 asked, "Can you repeat that?" with each</p>	F 250	<p>audiology referral. The audit results will be brought to QA monthly. Audits will begin 09/11/17. Corrective Actions will be completed 09/15/17</p>		

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F 250	Continued From page 3 conversation, and stated, "I need a hearing aid." On 8/9/17 at 9:00 am, Resident #8 stated she did not currently have a hearing aid. She stated her family member purchased a hearing aid for her "a long time ago," but it didn't work well. Resident #8 stated she had not had her hearing assessed and had not been fitted for a hearing aid. On 8/10/17 at 2:50 pm, the LSW (Licensed Social Worker) stated she discussed Resident #8's need for a hearing aid with the resident's family members, who declined the request to buy a hearing aid for Resident #8.	F 250			
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 252		9/15/17	

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F 252	Continued From page 4 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain a homelike environment in the shower room. The failure created the potential to negatively affect the comfort and psychosocial well-being of 9 of 10 residents (#1-6 and #8-10) reviewed for homelike environment, as well as any resident using the shower room. Findings include: On 8/10/17 at 11:00 am, the floor of the communal shower room was observed with missing and mismatched tiles surrounding the drain. The back wall of the shower was observed with a tile pushed back and a hole in the bottom left corner. The Maintenance Director stated the floor needed retiling, but the grout took 48 hours to dry. The Maintenance Director said, "It is hard to find that time, it would mean the residents would have to be taken to the assisted living side for showers."	F 252	F252 Corrective Actions: Changes were made in the shower room to replace the missing tiles on the floor and to fix the hole on the back wall, with regards to residents <input type="checkbox"/> #1-6, and #8-10. Identification of others affected and corrective actions: Any resident could have been affected. The changes made in the shower room would provide a more homelike environment for our current residents, Measures to ensure that the deficient practice does not happen again: Maintenance was educated on the importance of ensuring a homelike environment, in the shower room, for the comfort and psychosocial wellbeing of the residents. Monitor corrective actions: Administrator or designee will audit the shower room to ensure there are no holes in the wall, or missing tiles for 6 weeks. The audit results will be brought to QA monthly. Audits to begin 09/11/17		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use	F 279		9/15/17	

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F 279	<p>Continued From page 5</p> <p>the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure Care Area Assessments (CAAs) included accurate data from the Minimum Data Set (MDS) assessment. This failed practice affected 1 of 10 (#8) residents reviewed for initial care plans and created the potential for harm if residents' needs were not met due to inaccurate data derived from the MDS and CAA. Findings included:</p> <p>Resident #8 was admitted to the facility on 8/17/12, and readmitted on 1/14/17, with diagnoses that included glaucoma, chronic kidney disease, and major depressive disorder.</p> <p>On 5/31/17, the annual MDS assessment documented Resident #8 experienced moderate difficulty hearing, and required the speaker to increase volume and speak distinctly.</p> <p>On 5/31/17, the CAA for Communication</p>	F 279	<p>F279 Corrective Actions: Regarding resident #8, the care plan was reviewed with the recent MDS to ensure accurate information through a care plan IDT meeting. Identification of others affected and corrective actions: Current residents with a hearing loss will be identified and the care plan/MDS will be reviewed and updated, as appropriate. Measures to ensure that the deficient practice does not happen again: The Licensed Social Worker, MDS Nurse and DON will be educated, on the assessment, MDS and care planning process, as it relates to hearing, to ensure accuracy. Monitor corrective actions: DNS or designee will monitor the hearing in the MDS to the CAA, for accuracy for 6</p>		

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F 279	Continued From page 7 documented Resident #8 experienced impaired receptive communication, but did not experience an actual hearing impairment. Resident #8's Care Plan, dated 9/1/15 and revised on 8/22/16, documented Resident #8 was at risk for a communication problem related to minimal hearing deficit. Interventions directed staff to increase phone volume when Resident #8 conversed on the phone, consider Resident #8's position when in groups, activities, and the dining room to promote effective communication with others, and advised that Resident #8 wore a hearing aid in the left ear. On 8/10/17 at 2:50 pm, the LSW stated, "Interesting enough, things she [Resident #8] wants to hear she can."	F 279	weeks`. The audit results will be brought to QA monthly. Audits will begin 09/11/17		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 315		9/15/17	

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F 315	<p>Continued From page 8</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure staff reassessed the continence status of 2 of 10 residents (# 4 and #6) reviewed for incontinence. This failed practice created the potential for harm if residents experienced a decline in their ability to remain as continent as clinically possible. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 2/13/13, and readmitted on 4/16/15 and 2/19/17, with diagnoses that included altered mental status, major depressive disorder, pain in the right leg, polyneuropathy (nerve tingling and/or numbness), and edema.</p> <p>Resident #4's Minimum Data Set (MDS) assessment, dated 3/13/17, documented</p>	F 315	<p>F315 Corrective Actions: Resident #4 and 6 were reassessed and reviewed for their bowel & bladder assessment. Resident #4 was changed to a check and change at 0000 & 0400, per resident request for comfort, during the night (Resident states "I do not want to get up to the toilet during the night"). Resident is agreeable to toilet during the day, but did not want to change her toileting at this time. Resident #6 remained on a toileting program per evaluation and resident preference. Identification of others affected and corrective actions: Any resident could have been affected. Current residents, on bowel and bladder</p>		

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NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 9</p> <p>severely impaired cognition; short and long term memory impairment; extensive staff assistance required for transfers, personal hygiene, and toileting; frequent bladder incontinence; toileting program attempted with no improvement; currently on a toileting program.</p> <p>A Care Area Assessment (CAA) documented "modifiable factors" contributing to Resident #4's urinary incontinence included delirium, medications, environmental factors, and restricted mobility. The CAA documented Resident #4 exhibited signs/symptoms (s/s) of delirium, including an acute change in mental status; continuous inattention; a fluctuating alteration in level of consciousness; received Hydrochlorothiazide (diuretic) for edema; experienced urinary urgency and frequent urinary incontinence; and required the extensive assistance of two staff with toileting and pericare. The CAA additionally documented Resident #4 did not walk, wore adult incontinence briefs, received staff toileting assistance at midnight and 4:00 am, staff would cue the resident to toilet at regular intervals, and the resident would continue on a toileting schedule as outlined by the Bowel and Bladder Nurse.</p> <p>A 3-day Voiding Diary, dated 2/23/17, documented Resident #4 was continent, incontinent, and an additional 4 days of data was not needed. There was no response on the Voiding Diary in an area inquiring of staff whether Resident #4 was a candidate for prompted, "habit training," and/or scheduled toileting, but did document, "The resident is currently on a bladder retraining program."</p>	F 315	<p>training, will be reassessed for appropriateness, and if any changes are required to the training program</p> <p>Measures to ensure that the deficient practice does not happen again: Nursing staff will complete training on Restorative Nursing: Bowel and Bladder training. Additionally, the MDS nurse will be placed in the course, through AANAC, for Care Area Assessments and MDS 3.0. Monitor corrective actions: DON or designee will audit bowel and bladder assessments and appropriateness for training for 12 weeks. The audit results will be brought to QA monthly. Audits will begin 09/11/17 Corrective Actions will be completed 09/15/17</p>		

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F 315	<p>Continued From page 10</p> <p>The 3-day Voiding Diary documented the following:</p> <p>* 2/20/17 - Incontinent at 6:00 am, 9:00 am, 12:00 pm, 4:00 pm, and 6:00 pm; continent from 7:00 pm to 5:00 am.</p> <p>* 2/21/17 - Incontinent at 1:00 am, 4:00 am, and 5:00 am; continent from 6:00 pm to midnight.</p> <p>* 2/22/17 - Incontinent at 4:00 am and 7:00 am; continent from 8:00 am to 3:00 pm.</p> <p>Resident #4's clinical record did not contain documentation of additional bowel and bladder continence assessments after 2/23/17.</p> <p>Resident #4's care plan, revised 6/27/17, documented:</p> <p>* "... weakness, impaired mobility, history of right hip fracture, history of CVA [cerebrovascular accident or stroke], and impaired cognition." Interventions included 1 staff assistance required for toileting, gait belt for "stand and pivot onto toilet," and staff assistance with pericare.</p> <p>* "... incontinence r/t [related to] impaired mobility, impaired cognition, [and] poor control." Interventions included, "Check as required for incontinence ... encourage fluids during the day to promote prompted voiding responses and provide adequate fluid intake daily. Voiding routine: Toilet at [midnight] and [4:00 am]."</p> <p>A Bowel and Bladder Progress Note, dated 5/1/17, documented Resident #4 experienced bowel and bladder incontinence, was toileted per</p>	F 315			

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F 315	<p>Continued From page 11</p> <p>a toileting program at bedtime, midnight, and 4:00 am, and that staff would continue to assess and notify the physician of any changes</p> <p>A Bowel and Bladder Progress Note, dated 7/28/17, documented staff would continue to assess Resident #4 for further changes in bowel and bladder status and that no changes to the resident's care would be made at that time.</p> <p>Daily bladder continence tracking completed by Certified Nurse Aides from July 2017 to 8/11/17 recorded only summarized information from 6/12/17 to 8/11/17 that documented Resident #4 was continent 22 percent of the time and incontinent 77 percent of the time. No specific dates/times were provided.</p> <p>On 8/10/17 at 2:40 pm with the Bowel and Bladder Nurse (Registered Nurse (RN) #1) and the Director of Nursing Services (DNS), RN #1 stated residents were assessed upon admission with the "3-day Voiding Diary" in which staff were to log every occurrence of continence, incontinence, and voiding in a toilet. RN #1 stated the Voiding Diary was placed in the Assessments section of the resident's chart. RN #1 stated she documented quarterly notes for incontinent residents, but had "never been responsible" for residents' bowel and bladder status and did not know how to perform a bowel and bladder assessment. RN #1 stated Resident #4 could not toilet after falling and breaking a hip, but was now alert and did not like to experience incontinence. RN #1 stated all residents are toileted before meals.</p> <p>On 8/11/17 at 2:10 pm, Certified Nurse Aide</p>	F 315			

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F 315	<p>Continued From page 12</p> <p>(CNA) #1 stated Resident #4 was "super" confused, had dementia, and had difficulty hearing others. CNA #1 said Resident #4 could sometimes communicate her needs, but at other times spoke in "word salad." CNA #1 stated staff were supposed to toilet the resident 2 hours after meals, and that Resident #4 required the extensive assistance of 2 staff with transfers, toileting, and cueing to toilet. CNA #1 stated she worked the day shift and that Resident #4 was "usually" wet with incontinence when staff assisted her out of bed each morning.</p> <p>The facility failed to reassess Resident #4's continence status, provide bladder retraining, or implement interventions to help improve the resident's continence status to the highest practicable level.</p> <p>2. Resident #6 was admitted to the facility on 5/30/12, and readmitted on 10/21/14, with diagnoses that included hemiplegia and hemiparesis following a CVA (cerebrovascular accident - stroke), weakness, abnormal gait/mobility, anxiety disorder, pain, cataract, and glaucoma.</p> <p>Resident #6's annual MDS, dated 9/13/16, documented moderately impaired cognition, extensive staff assistance required with transfers and toileting, frequent bladder incontinence, no toileting program trial, and not enrolled in a toileting program.</p> <p>Resident #4's CAA documented extensive staff assistance was required for toileting, the resident experienced urinary urgency and "frequent" incontinence at night, used a female urinal at</p>	F 315			

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F 315	<p>Continued From page 13</p> <p>night with staff assistance, and required a sit-to-stand mechanical lift for transfers. Modifiable factors contributing to the resident's urinary incontinence included pain, constipation, unspecified environmental factors, and restricted mobility. Staff noted Resident #6 sometimes removed her adult brief to void on a bed pad; was offered toileting assistance before and after meals, as well as mid-morning, mid-afternoon, before bed, as needed at night; and according to a "voiding schedule." Staff also reminded Resident #6 to activate her call light for toileting assistance and to not throw soiled incontinence products onto the floor of her room.</p> <p>Resident #6's care plan, revised 6/27/17, documented:</p> <p>* "Frequent bladder incontinence r/t [related to] impaired mobility and poor control." Interventions included the provision of adult incontinence briefs; staff checks for episodes of incontinence; monitoring for brief and bed pad changes; 2-staff assistance with transfers and toileting before and after meals, mid-morning, mid-afternoon, before bed, and as needed at night; use of a female urinal at night.</p> <p>A Bowel and Bladder Progress Note, dated 2/20/17 at 6:55 pm, documented staff would continue to assess Resident #4 for changes in bowel and bladder status and would notify the physician of any changes.</p> <p>A Bowel and Bladder Progress Note, dated 5/1/17 at 11:59 am, documented staff would continue to assess Resident #4 for changes in bowel and bladder status and would notify the</p>	F 315			

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F 315	<p>Continued From page 14 physician of any changes.</p> <p>A Bowel and Bladder Progress Note, dated 7/28/17 at 2:21 pm, documented staff would continue to assess the resident for changes in bowel and bladder status.</p> <p>On 8/10/17 at 11:30 am, the MDS nurse, who said she assisted the Bowel and Bladder nurse when completing the MDS, stated Bowel and Bladder Progress Notes were used to determine the need for a toileting program and formulate care plan interventions. The MDS Nurse stated the 3-day Voiding Diary was completed for new admissions only and residents' episodes of incontinence were documented by CNAs per shift rather than per incident.</p> <p>Daily bladder continence tracking completed by Certified Nurse Aides from July 2017 to 8/11/17 recorded only summarized information from 6/12/17 to 8/11/17 that documented Resident #6 was continent 56 percent of the time and incontinent 43 percent of the time. No specific dates/times were provided.</p> <p>On 8/11/17 at 2:10 pm, CNA #1 stated Resident #6 was sometimes not "super compliant" with incontinent assistance and cares. CNA #1 stated 2 staff were required to assist Resident #6 transfer from the bed to a wheelchair or from a wheelchair to the commode using the sit-to-stand mechanical lift. CNA #1 stated Resident #6 was able to alert staff when she needed to toilet, and that staff tried to encourage the resident to use the call light for assistance.</p> <p>On 8/10/17 at 2:40 pm, RN #1 stated Resident</p>	F 315			

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F 315	<p>Continued From page 15</p> <p>#6 was able to ask staff for toileting assistance, which she usually did before and immediately after meals. RN #1 stated Resident #6 was usually continent during the day and was on a toileting program at night, although the program did not specify times at which Resident #6 was to be offered assistance to the toilet. At this time, the DNS provided a urinary incontinence assessment form that included onset, products used, voiding pattern, dietary/fluid intake, medications review, functional and cognitive factors, environmental factors, type of incontinence, reversible factors, irreversible factors, plan, and whether to proceed with a check and change program. RN #1 and the DNS stated they picked only a few incontinent residents at a time and focused their attention on those residents who could improve in their continence status.</p> <p>On 8/11/17 at 9:00 am, the DNS stated she was unable to find Resident #6's admission bowel and bladder continence assessment and had no further assessments of Resident #6's bowel and bladder continence status.</p> <p>The facility's Bowel and Bladder Assessment Policy, revised May 2014, documented: "It is the policy of this facility that a bowel and bladder assessment will be completed with the first fourteen (14) days of admission to identify an elimination pattern. The purpose of the bowel and bladder assessment is to offer a structured, goal oriented approach with the intent that the resident attains the highest level of independence in bowel/bladder continence. This program will also focus on the resident's ability to improve continence independently. Procedures:</p>	F 315			

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F 315	Continued From page 16 Initiate a bowel and bladder screen within twenty-four (24) hours of admission. A bowel and bladder assessment will be completed. The bowel and bladder nurse will identify if the resident is a candidate for the bowel and bladder retraining program. Resident's care plan will be updated accordingly. Residents will be re-evaluated by the bowel and bladder nurse quarterly and when a significant change occurs."	F 315			
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve foods that were tender, flavorful, and pleasing in appearance to residents. This deficient practice had the potential to affect all residents who ate their meals prepared at the facility. Findings include: During a group interview with 12 residents on 8/8/17 10:00 am, 3 residents stated the meat they were served for meals was tough for those without their natural teeth. On 8/9/17 at 8:30 am, the Account Manager for Dietary Services (AMDS) stated 8 residents	F 364	F364 Corrective Actions: In-servicing was provided to the cook of the meal sited and, subsequently, the same in-service training was provided to all Dietary Staff. This potentially affected all residents who eat meals in the facility. Identification of others affected and corrective actions: Any resident could have been affected. The above in-servicing will affect all current residents. Measures to ensure that the deficient practice does not happen again: Dietary Staff education was provided on	8/15/17	

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F 364	<p>Continued From page 17</p> <p>received mechanical soft foods and no residents received a pureed diet.</p> <p>The 8/9/17 dinner meal menu included garlic herbed pork loin, brown gravy, confetti vegetable couscous, creamed spinach, a dinner roll/bread, margarine, pineapple tidbits, milk, and coffee or hot tea.</p> <p>The recipe for the garlic herbed pork loin included boneless pork loin, fresh peeled whole clove garlic, dried rosemary leaf, ground black pepper, and salt. The cooking procedure directed staff to insert garlic cloves into the meat, and then rub the combined seasoning mix on the pork loin. The recipe directed staff to bake the pork loin at 325 degrees Fahrenheit (F) for 1-1 ½ hours or until done. For ground consistency, the recipe further directed staff to measure out the desired number of servings into a food processor and grind to the appropriate consistency, adding gravy or broth to moisten the meat if needed.</p> <p>On 8/9/17 at 3:45 pm, the cook completed preparation of the vegetable couscous, which sat in an uncovered saucepan on the stove. At 4:45 pm, the cook removed aluminum foil from the pork loin baking pan, which had no residual fluid in the bottom of the pan, and placed the regular-texture sliced pork loin on the steam table. At 4:54 pm, the Cook placed several slices of pork loin into a food processor to chop the meat into a mechanical soft texture. The Cook did not add any gravy or broth to the food processor during the process. Once the meat was altered to a mechanical soft consistency, the Cook spooned it into a pan on the steam table. At 4:47 pm, the Cook transferred the vegetable</p>	F 364	<p>proper roasting/cooking techniques to ensure proper training in food preparation. Additionally, on proper plate presentation and garnish, and performance improvement.</p> <p>Monitor corrective actions: Administrator or designee will audit for palatability and presentation for 6 weeks. Test trays for lunch and dinner will be passed to a random employee to be evaluated 5x/week for two weeks, then 3x/week for two weeks, then 2x/week for two weeks. Additionally, a resident will be interviewed at both lunch and dinner on their satisfaction of the meal, and particularly the meat serving. The audit results will be brought to QA monthly. Audits will begin 08/15/17 Corrective Actions will be completed 8/15/17</p>		

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F 364	<p>Continued From page 18</p> <p>couscous, which came out of its cooking container in a single lump, into a pan on the steam table.</p> <p>A test tray of the meal was requested and delivered to surveyors at 5:35 pm with the Area Manager for Dietary (AMD) and AMDS present during temperature and taste tests. The test tray included regular-texture pork loin, mechanical soft pork loin with gravy, creamed spinach, vegetable couscous, and pineapple tidbits. At 5:38 p.m., the AMDS tested the temperature of each item on the tray and recorded 136 degrees F for the mechanical soft pork loin; 136.5 degrees F for the regular texture pork loin; and 153 degrees for the couscous. The AMD, AMDS, and 2 surveyors tasted each food item. The AMDS and 2 surveyors stated the couscous was bland, its texture was pasty and stuck together. The mechanical soft and regular texture pork loin were dry, although the mechanical soft pork loin had gravy, and there were no noticeable colors from the bell peppers or mushrooms in the couscous.</p> <p>On 8/11/17 at 8:25 am, the Registered Dietitian (RD) stated she tested temperatures, texture, and taste on occasion and that she would expect staff to improve food palatability if the item was not up to standard.</p> <p>On 8/11/17 at 9:10 am, the Cook stated he occasionally tasted the food he prepared and noted, "but not often."</p> <p>On 8/11/17 at 10:10 a.m., the Administrator stated he expected the facility's food to be palatable and at the appropriate temperature</p>	F 364			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 364	Continued From page 19 when served to residents. The Administrator stated the facility tested its food to improve service to the residents, who tended to prefer meat and potatoes rather than items such as couscous. The facility's undated Food: Quality and Palatability policy documented: "It is the center's policy that food is prepared by methods that conserve nutritive value, flavor, and appearance. Food is palatable, attractive and served at the proper temperature."	F 364			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001170	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2017
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility from August 7, 2017 through August 11, 2017. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Ina Tso RN	C 000		
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain the minimum number of bathing facilities for the number of licensed beds. This affected 9 of 9 (#s 1-6 and 8-10) sampled residents residing in the facility and had the potential to affect all residents who reside in the facility. Findings included: The facility was licensed for 45 certified beds. At the beginning of the survey process, 30 residents resided in the facility. On 8/10/17 at 11:00 am, the Bathing Room was observed with 2 bathtubs filled with equipment and one shower stall in usable condition for	C 422	C 442 On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds. It was determined that the facility failed to maintain the minimum number of bathing facilities for the number of licensed beds. A written request for a waiver was made 08/31/2017.	9/15/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/02/17
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001170	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2017
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NAME OF PROVIDER OR SUPPLIER DISCOVERY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SHANAFELT STREET SALMON, ID 83467
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 422	<p>Continued From page 1</p> <p>residents.</p> <p>The Administrator stated he was aware the facility did not have the required number of bathing facilities for the number of licensed beds. The Administrator stated the facility had historically been granted a waiver for this requirement, as the number of bathing facilities was sufficient to meet resident bathing needs and preferences, and the facility planned to request a waiver again.</p> <p>Individual and group resident interviews and resident family interviews conducted throughout the survey revealed no difficulties with residents receiving baths or showers. No concerns with resident bathing were identified through resident reviews.</p> <p>However, the Director of Maintenance acknowledged that he was unable to maintain the tile and grout in the shower room without causing a hardship to residents, such as going to another attached provider for showers.</p>	C 422		